Health Services
LOS ANGELES COUNTY

June 1, 2010

313 N. Figueroa Street, Suite 912
Los Angeles, CA 90012

Tel: (213) 240-8101
Fax: (213) 481-0503

www.dhs.lacounty.gov

TO: Each Supervisor

FROM: John F. Schunhoff, Ph.D.
Interim Director

SUBJECT: **SUPPLEMENTAL REPORT ON DEPARTMENT OF HEALTH SERVICES' (DHS) CASH FLOW**

As stated in the Auditor-Controller's General Fund and Hospital Fund Cash Flow Projections report to your Board on May 17, 2010, this is to provide additional information related to delays in various payments owed to the Department.

Background

In the normal course of day-to-day operations, the Department provides medical services to patients at its facilities and then files claims or cost reports for the services provided in order to receive reimbursement. Because reimbursement is retrospective, there is a continuing need for the Department to receive advances from the County General Fund to support the daily operations of its hospitals and other facilities. It is not uncommon that half or more of anticipated revenues are not received in the fiscal year during which the services were provided. Retrospective reimbursement is an inherent part of the fee-for-service reimbursement structure and is experienced throughout the hospital industry.

However, at the present time, there is a combination of additional factors which result in increased operating advances to the Department: first, there are outstanding revenues owed to the Department by the State. Also, additional revenues or subsidies are currently unavailable to help offset the Department's structural deficit. The Department continues to actively pursue additional revenue sources, e.g., the Hospital Provider Fee described below, and is also currently working closely with the State and other stakeholders on a new 1115 Waiver.

Approximately 50 percent of DHS' Medi-Cal inpatients are already approved Medi-Cal beneficiaries when they present for treatment and, for those patients, post discharge, it takes about 30 days to gather the data needed to bill. Once the necessary data is obtained, DHS must obtain State review and approval of each day of hospitalization through the Treatment Authorization Request (TAR) process. Once

the TAR is approved, the account is billed to the State and payment is received within approximately 14 days.

For non-Medi-Cal patients who seek treatment at DHS facilities, a screening process is completed to determine if they may be eligible for Medi-Cal. For those patients who appear to meet Medi-Cal eligibility requirements, DHS processes a Medi-Cal application. The length of time required to complete the Medi-Cal application process varies from approximately 45 days for a Family Aid Medi-Cal application to 90 -120 days for a Disabled Medi-Cal application (a patient's disability status must be certified by the State). Once the Medi-Cal application is approved, the TAR process and billing must be completed.

A TAR must be completed for each admission and each day of a continued hospital stay and, until approval is obtained, DHS is not able to bill the State. As an example, if it takes 120 days to approve a Disabled Medi-Cal application and 45 days for the State to approve a TAR, the routine billing process can take up to 165 days. This example demonstrates that the normal interval between the provision of Medi-Cal services and the receipt of reimbursement can be relatively long. If additional lag times occur, as is currently the case, the interval between services and reimbursement lengthens and cash flow is negatively impacted.

Since Medi-Cal accounts for approximately 50 percent of the Department's revenue, the delays associated with the Medi-Cal approval, TAR, and billing processes have a significantly negative impact on cash flow.

Medi-Cal TARs

As a result of State employee furloughs, hiring freezes, and lack of overtime, DHS has amassed a TAR backlog of approximately 10,000 admissions. The current TAR backlog of nearly 10,000 TARs represents approximately 50,000 days, each day requiring State Medi-Cal Field Office (MFO) review and approval before being processed for payment. This represents approximately $51.0 million. The State MFO in Los Angeles has made efforts to reduce this backlog by having "TAR parties" (additional review nurses are assigned for a short period of time to concentrate on processing backlogged TARs); however because of concurrent TAR review workload and State employee furloughs, the backlog continues to grow. Untimely TAR processing has a direct and negative impact on Departmental cash flow.

Various solutions to resolving the backlog have been considered, including hiring additional MFO staff. However, there is concern that even if the State hired additional staff to meet TAR processing needs throughout the State (which is unlikely given the State's fiscal situation), the TAR denial rate could increase as new, inexperienced personnel grapple with the subjective and inexact guidelines of TAR review. The County has proposed substituting the manual TAR process with an electronic,

evidence-based Utilization Management Decision Support system (InterQual) as part of the new 1115 Waiver to resolve this problem going forward. In addition, the County has outside counsel researching potential legal options to address the current TAR backlog problem.

Cost Based Reimbursement Clinics (CBRC)

The Department bills and receives an interim CBRC rate for each visit for hospital and non-hospital based ambulatory care services for Medi-Cal patients. Once the CBRC billing is submitted, payment is received within approximately 14 days. The process requires submission of an annual cost report which is then audited by the State. The audit results are reconciled with actual payments and if there is a shortfall in payments by the State, an additional amount is owed to the County. Also, based on the audit, the interim rate may be adjusted.

The State's staffing cutbacks and furloughs have also impacted the CBRC audit process resulting in significant delays in receiving final audit settlement payments. The interim rate has not been adjusted since Fiscal Year (FY) 2004-05 and the last completed audit was for FY 2005-06. The attached schedule reflects the variance between anticipated CBRC revenue and amounts paid, currently estimated at approximately $221.5 million for FYs 06-07 through 09-10.

The County worked with the State on this issue and proposed an interim audit settlement for FYs 2006-07 through 2009-10, and an adjustment to the interim rates for FY 2010-11. The State agreed to part of the County proposal and included funds in the Governor's May Revise budget to pay the FY 06-07 interim audit settlement in the amount of $54.3 million. DHS will work with the State to include additional interim audit settlements for FYs 2007-08 and 2008-09 in future State budgets. The State also agreed to include in the May Revise an increase in the interim rate for FY 2010-11, which is expected to resolve the problem going forward.

Hospital Provider Fee

The Centers for Medicare and Medicaid Services' (CMS) has not yet approved the Hospital Provider Fee. If approved, the quarterly value to DHS is approximately $34.3 million through December 31, 2010. [An extension of the enhanced Federal Medical Assistance Percentage (FMAP) through June 30, 2011 was recently amended out of the House of Representatives' version of H.R. 4213, the American Jobs and Closing Tax Loopholes Act. Strong legislative efforts are underway to get the FMAP extension included in the Senate's amendments to H.R. 4213. If the FMAP enhancement, which increases California's federal/ state share from 50:50 to 62:38, is enacted, the Hospital Provider Fee would also likely be extended through additional State legislation bringing additional revenue to the Department through June 30, 2011.]

The State has indicated that discussions with CMS are continuing regarding CMS concerns with various aspects of the fee and distribution methodology. If the fee is ultimately approved, it is most likely that the effective date will be April 2009. However, if CMS requires material revisions to the Hospital Provider Fee, it will become necessary to secure agreement from the hospital community on the changes and new legislation may also be required. A successful outcome in these circumstances may be difficult to achieve.

Given the current uncertainty surrounding this issue, it is unknown at this time whether or not these revenues will ultimately be realized, what amount may be coming to the Department if the provider fee is approved by CMS, or how long any delay might be before these revenues may be realized.

If you have any questions or need additional information, please let me know.

JFS:aw

Attachment

c: Chief Executive Office
County Counsel
Executive Office, Board of Supervisors

COUNTY OF LOS ANGELES - DEPARTMENT OF HEALTH SERVICES
OVERVIEW OF MAJOR ISSUES IMPACTING DHS CASH FLOW
STATUS AS OF MAY 2010
FISCAL YEARS (FY) 2006-07 THROUGH 2009-10
($ in Millions)

Revenue	FY 06-07	FY 07-08	FY 08-09	FY 09-10	Total
Medi-Cal Treatment Authorization Requests (TARs)	$ 4.0	$ 2.7	$ 8.1	$ 36.1	$ 50.9
Cost-Based Reimbursement Clinic (CBRC)	49.4	70.7	74.3	27.1	221.5
Hospital Provider Fee	-	-	34.3	137.0	171.3
Total	$ 53.4	$ 73.4	$ 116.7	$ 200.2	$ 443.7